

Editorials

Maj Joshua M. Tobin, MD

I read with interest the article “Damage Control Resuscitation for the Special Forces Medic: Simplifying and Improving Prolonged Trauma Care” (JSOM 2009, Vol 9, Eds 3-4) by Dr. Risk and Mike Hetzler, 18D. I agree that resuscitation of the trauma patient is of paramount importance, and is an equal partner with the surgical procedure. Perfect surgery on a poorly resuscitated patient is just as fruitless as failed surgery on a well resuscitated patient.

I am excited to see this information being pushed out as far as possible. I am concerned, however, that this will put the SOF medic in a difficult position. I was a paramedic for many years before getting my medical degree and I understand the capabilities, and limitations, of medics. In my current assignment I work closely with the Pararescue community and, while deployed, have treated patients with NSW Corpsmen and SF 18Ds. I have great admiration for these dedicated medical Operators and am honored to serve with them.

However, we are not providing good leadership for these men by adding another extensive skill set to their already exhaustive credentials. Given the current deployment cycle and high ops tempo, it is a challenge for the PJ/SOCM/18D/NSW Corpsman to maintain currency in their operational skill sets (weapons, MFF, etc). It is not reasonable to expect a medic, no matter how capable and motivated, to maintain another “critical care” skill set.

The authors assert “The scope and duration of care provided by SF medics may equate to that of a physician at more than one conventional level.” If this is the case, then we need to provide field medical officer support for these operations. I propose that a tactical evacuation model with a medical officer and SOCM be designed to move casualties from the point of injury to a surgical facility, providing experienced critical care en route.

TACEVAC puts a medical officer/SOCM team on a QRF platform. This is not unlike the crew configurations in several foreign militaries (e.g., Australia, Israel) and some civilian helicopter EMS systems in the U.S. This is where damage control resuscitation can have the greatest impact. The more extensive skill set and seasoned experience of a critical care medical officer here can make all the difference down the chain of care.

Rangers have long sent their battalion surgeons to Ranger school. Special Forces is again sending some of their medical officers through the SFQC. The Air Force has developed and deployed Special Operations Critical Care Evacuation Teams (SOCCET) led by a critical care medical officer. We have in the Special Operations medical community, a group of rigorously selected, well trained, board certified physicians with extensive downrange combat experience. We must use them in innovative ways to address the evolving nature of medical care in this long war.

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EDITORIAL REBUTTAL

COL Greg Risk, MD

In response to Maj Tobin's editorial comments regarding damage control resuscitation and prolonged care, several issues require clarification. Several real world missions, which placed SOF medics in a situation with critical patients requiring prolonged care for periods in excess of those commonly encountered, drove the application of this approach. Several of these occurred outside of the Iraq and Afghanistan theaters of operation in nations that had well developed medical evacuation systems and robust levels of care to include access to surgical assets and blood component therapy, which the author may be using as his reference. On any given day, Special Operations forces (SOF) are active in 40 to 50 countries world wide, many in austere environments with little or no medical support except that organic to the deployed unit. The writer's comments are well intended, but fail to appreciate the perspective of the SOF medic. Some of these may have to do with the author's experiences doing evacuation work, and some may be service specific. This is not meant to denigrate the intent, as we each bring our service and individual background to looking at any given issue. Our project was undertaken with this in mind and a realization that with the maturation of both theaters and availability of medical assets, some of the traditional skills were eroding and in need of updates in keeping with advances in medical care.

First, the job description of paramedics, which the writer was, and that of forward deployed SOF medics are not comparable. The emergency medical technician – paramedics (EMT-Ps) work in prehospital systems within the Continental United States (CONUS). One of the challenges faced with continuing the National Registry of Emergency Medical Technicians – Paramedic (NREMT-P) program at the Joint Special Operations Medical Training Center (JSOMTC) has been finding the curriculum time for the pediatrics, geriatrics, and cardiac care required by paramedics. Our SOF medics are faced with managing severe trauma and critically injured patients with far more capabilities and for more prolonged periods of time than expected of paramedics.

Second, we are not "adding another extensive skill set" to SOF medic expectations. The ability to provide prolonged care has long been part of the doctrine, curriculum, and history of Special Operations medicine. We are updating this to include damage control resuscitation (DCR) for those casualties in more remote areas, or in a true unconventional warfare (UW) scenario for whom rapid transport and surgical intervention are not feasible in a timely fashion. Again, the writer's comments are based upon relatively recent ex-

periences in the current conflicts, and focused more on critical care transport. A more extensive review of UW medicine from the Spanish Civil War, the Philippine/U.S. guerrilla operations against the Japanese, as well as Office of Special Services (OSS), and partisan European operations in World War II, SOF missions in Vietnam, all the way up to early Iraqi and Afghanistan missions conducted by SOF, all reinforce a need for prolonged care. If we could transport all critically injured patients to the combat support hospital or operating table in one hour, then we would have little need for the concepts outlined in the article. The missions that initiated this project led us to believe that we cannot guarantee our patients that they will be evacuated in short order.

Third, the author also makes the statement that this is a competing skill set, one of many along with "weapons, military free fall, etc", which might be beyond our SOF medics. Let us be clear, our primary mission as SOF medics is medicine. Subordinating medical skills to other tasks negates our reason for selecting, training, and sustaining SOF medics. Rather than providing "not good leadership," we are confident that the SOF medics can maintain this skill set. As we have noted in other forums, translating the use of agents such as Factor VIIa, lyophilized plasma, and/or platelets as an "internal hemostatic" is a natural progression of the Tactical Combat Casualty Care (TCCC) concept promulgated by Butler, Hagmann, et al., originally. As we have previously noted, the only treatment for hemorrhagic shock is blood replacement; most other therapies are temporizing, and the unresuscitated shock patient faces a dismal outcome. The natural continuation of this is the ability to provide this therapy at the appropriate time, place, and manner.

The writer next contends that if SOF medics are going to be performing duties normally reserved for physicians in conventional units, then we need to "provide field medical officer support" and proposes a medical officer or Special Operations Combat Medic (SOCM) to move patients from point of injury to surgical care. While we are doing this to a limited extent in current conflicts, this misses the point on two counts. First, there are not enough medical officers available to provide this care, and only a few medical officers are qualified to operate with SOF far forward. Secondly, the author is again viewing this through his personal prism, but this is not an evacuation issue. The entire reason SOF medics are trained to perform advanced medical procedures and are so carefully selected and trained is to enable them to function at this much higher level, whether it is providing advanced

airway management, treatment normally reserved for the anesthesiologist/anesthetist, or use of surgical skills, laboratory training, and so forth. We have and will repeatedly be required to care for U.S., allied, coalition, and local forces as well as the indigenous population, some of which will face prolonged times to evacuate, or for whom evacuation is not possible. One of the authors spent considerable time caring for local forces in Central America 25 years ago for whom no evacuation was possible. The care provided determined our credibility with local national forces. The ability to develop and sustain these forces, and to operate “by, with, and through” may be the key to our success in the war on terrorism.

We truly appreciate the writer’s commentary, and it affords us the opportunity to clarify some of the misunderstanding associated with pushing what is a well-established concept at higher levels of care, down to the SOF medic level. As with the development of SOF medicine and introduction of TCCC, it will challenge some previous dogmas. Unlike the writer, and others of similar viewpoint, we will never be able to have sufficient physicians/medical officers to be in all places at all times. We believe updating what have been traditional SOF medicine roles for the 21st century with scientifically proven treatments and technology is more than justified when looked at with a more broad geographic, operational, and historical perspective.

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EDITORIAL

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Medical sonography (ultrasonography) is an ultrasound-based diagnostic medical imaging technique used to visualize muscles, tendons, and many internal organs, to capture their size, structure, and any pathological lesions with real time tomographic images. There is no question as to whether or not ultrasound brings to bear an enhanced medical capability for the patient. Using portable ultrasound (US) to visualize the vein and to guide needle insertion is questionable; in my previous discussions of the US technique. I still contend it is very difficult (or nearly impossible) to visualize most accessible veins and borders on the realm of bad medicine if conducted by the 18D. I'm sure there is an anecdotal situation where someone could infer this procedure prudent; my stance is not against the isolated incidence or situation where this might be applicable.

At present there lacks a training module either in SOCM or SFMS/SOIDC where the 18D or 68WW1

is trained to a suitable standard that would warrant the broad dissemination of a piece of equipment that has an enormous price tag to field, not to mention maintain.

The role of the Special Forces medic encompasses many areas of medical knowledge. Adding an additional skill set (and recertification) into the rucksack of our medics' compounds a growing trend; let's get rid of this so we can accommodate that. I'm guessing the intent is to effect the MOS phase of the training to ensure interoperability and standards of training. In the last Special Operation Combat Medic Training Task Survey, medics indicated "training needs to start being emphasized in routine sick-call problems." This might be an area we focus on in developing the 18D and 68WW1 skill set. Okay, we acquiesce and purchase this item. Who maintains them and where on the MTOE do we put them ... ODA, ODB, or ODC? This will inevitably impact training, sustainment training, and training opportunities.